Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

J T DILGER JR MD
6718 MONTAY BAY DRIVE
SPRING TX 77389

Respondent Name

OLD REPUBLIC INSURANCE CO

Carrier's Austin Representative Box

Box Number 44

MFDR Tracking Number

M4-12-1179-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Designated Doctor Exam for MMI & IR faxed 4/18/11…Designated Doctor Exam…DDE…DDE…Review of surveillance tape with report"

Amount in Dispute: $1,150.00 + interest for 280 days

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response for consideration to this dispute.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 18, 2011	99456-WP-W5	$350.00	$350.00
	99456-WP-W5	$300.00	$300.00
	99456-WP-W5	$150.00	$150.00
	99456-WP-W5	$150.00	$0.00
April 14, 2011	99199	$200.00	$0.00
TOTAL		$1,150.00 + interest for 280 days	$800.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §134.130 sets out the procedures for Interest for Late Payment on Medical Bills and Refunds.
2. 28 Texas Administrative Code §133.240 sets out procedures for medical payment and denials.
3. Texas Labor Code §413.019 sets out procedures for Interest Earned for Delayed Payment, Refund, or Overpayment regarding medical services and fees.
4. Texas Labor Code §401.023 sets out procedures for computation of Interest or Discount Rate.
5. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
6. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
7. 28 Texas Administrative Code §134.1 requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
8. Texas Labor Code §413.011, requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.
9. Copies of the explanation of benefits were not submitted by either party. The disputed services will therefore be reviewed per the applicable Division rules and fee guidelines.

Issues

1. What is the Maximum Allowable Reimbursement (MAR) for CPT Codes 99456-WP-W5 and 99199?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor billed the amount of $950.00 for CPT code 99456-W5-WP with 1 (one) unit x 4 in Box 24G of the CMS-1500 for a Designated Doctor Examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). The requestor also billed the amount of $200.00 for CPT code 99199 for review of a surveillance tape and report. The Division order on the DWC032 was to determine MMI/IR to the left shoulder and lumbar spine. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Review of the submitted documentation supports that Maximum Medical Improvement (MMI) was assigned and per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Review of the narrative documentation submitted supports that MMI was assigned and 3 body areas were rated. To determine reimbursement for an IR, the method of calculating IR and the number of body areas/conditions are reviewed. The documentation supports that the requestor performed the Impairment Rating per AMA Guides to the Evaluation of Permanent Impairment, 4th Edition for the MAR per 28 Texas Administrative Code §134.204 (j)(4)(C)(ii)(II)(a) for the 1st musculoskeletal area used the Range of Motion (ROM) method on the left shoulder (upper extremities) is $300.00, the 2nd musculoskeletal area on the left hind foot/ankle (lower extremities) is $150.00 and Diagnosis Related Estimates (DRE) Category 2 method used on the 3rd musculoskeletal area on the lumbar spine(spine) is $150.00. The Division order on the DWC032 was to determine MMI/IR to the left shoulder and lumbar spine only. Therefore, IR to the left hind foot/ankle (lower extremities) is not payable. The combined Maximum Allowable Reimbursement (MAR) for the disputed CPT code 99456-W5-WP is $800.00.

   The requestor also billed the amount of $200.00 for CPT code 99199 for review of a surveillance tape and report. Division rule at 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 TexReg 3561, requires that services not identified in a fee guideline or a negotiated contract, shall be reimbursed at fair and reasonable reimbursement as specified in subsection (f) of this section. The Division finds that CPT code 99199 does not have an established relative value and the insurance carrier did not submit documentation to support that the carrier has assigned a relative value. Review of the documentation submitted by the parties to this dispute finds no documentation to support that an amount was pre-negotiated and/or contracted between the provider and carrier for the disputed CPT code 99199; therefore, the insurance carrier shall reimburse the provider the fair and reasonable rate in accordance with Division rule 28 Texas Administrative Code §134.1. Division rule at 28 Texas Administrative Code §134.1, which requires that in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section; be consistent with the criteria of Labor Code §413.011; ensure that similar procedures

provided in similar circumstances receive similar reimbursement; be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available." Division rule at 28 Texas Administrative Code §133.307 (c)(2)(G), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." The requestor did not submit nationally recognized published relative value studies, published commission medical dispute decisions, and value assigned for services involving similar work and resource commitments; medical dispute decision, and values assigned for services involving similar work and resource commitments. The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement. The requestor does not discuss or explain how payment of the request amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirement of Texas Labor Code §413.011(d) or Division rule at 28 Texas Administrative Code §134.1. The request for reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for CPT code 99199. Reimbursement cannot be recommended.

2. The respondent reimbursed the requestor the amount of $0.00. Therefore an amount of $800.00 is recommended for payment.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $800.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $800.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 23, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.